DOCUMENT RESUME

ED 173 021 RC 011 498

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TITLE	A Research Study of Casa Del Sol: A Viable Chicano Bilingual-Bicultural Alcoholism Treatment Modality.
PUB DATE	25 Apr 77
NOTE	53p.
EDRS PRICE	MF01/PC03 Plus Postage.
DESCRIPTORS	Acculturation; *Alcoholism; Cultural Awareness; Cultural Factors; *Culture Conflict; Drinking; Economic Disadvantagement; Evaluation Methods; *Males; *Mexican Americans; Models; *Program Evaluation; *Psychological Evaluation; Psychological Needs; Therapy
IDENTIFIERS	Alcoholism Treatment; Casa del Sol TX; *Chicanos; Hispanos

ABSTRACT

Alcoholism among Chicanos is principally due to structural deficiencies in the surrounding society. The frustrations and limitations brought on by the social structure constitute the principal cause of Chicano alcoholism. These include the major causative factors of poverty, racism and acculturation. In an attempt to address the problem of alcoholism among Mexican Americans, the Mexican American Unity Council implemented in 1974 "Casa del Sol," a federally funded alcoholism project which uses the intrinsic strengths of the Mexican American culture as part of the treatment process. Therapy is based on cultural assessment, culturally individualized treatment plans and the study of Chicano culture and history. The staff of the project are both bilingual and biculturally trained. To assess the effectiveness of the program a study was conducted in 1976 on 17 of the clients between the ages of 17 to 48. A questionnaire was filled out by the inpatient counselor as the client came into the program and thirty days after he left the inpatient unit. Data analysis showed that the treatment process was significant in increasing the attendance rate at Alcoholics Anonymous meetings and employment status and number of days worked. The number of days of hospitalization, alcoholism related arrests, number of days the client drank and the amount of alcohol consumed all decreased. This type of bilingual, bicultural treatment is a viable, realistic concept. (DS)

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WORDEN SCHOOL OF SOCIAL WORK

A RESEARCH STUDY OF CASA DEL SOL: A VIABLE CHICANO BILINGUAL-BICULTURAL ALCOHOLISM TREATMENT MODALITY

SUBMITTED IN PARTIAL FULFILLMENT

OF

SOCIAL WORK RESEARCH
(6342)

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April 25, 1977

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Rc011498

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

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INTRODUCTION

Alcoholism is one of many social problems that confronts contemporary American society. It respects no boundaries of sex, age, education or ethnicity and the negative consequences are many times of a severe nature. As a social ill, alcoholism has transpired itself over time and has survived a variety of attempts aimed at eradicating it. These, of course, have been legal restrictions (prohibition), social treatment programs and social constraints to identify a few.

The problem complicates itself by being interwoven with other factors that leaves the alcoholic person totally disabled. The toll it takes varies with the particular socio-economic situation of the individual. An alcoholic person within a high social strata will usually have accessibility to a variety of resources. In addition, the problem itself will become obscured and recognition of it will be surpressed.

For those in the lower social strata or within minority groups, alcoholism is a real problem. It is more visible, its impact is highly severe and attempts to alleviate it are many times too minimal, not effective and too late. This applies specifically to Mexican Americans who have alcoholism problems.

In an effort to address the problem of alcoholism among Mexican Americans, the Mexican American Unity Council embarked on October 1, 1974 to implement a Chicano* alcoholism program

*The terms "Chicanos" and "Mexican Americans" are used interchangeably to refer to those individuals who are natural born United States citizens and whose cultural and racial heritage stems from Mexico.

"Casa Del Sol". The program embodies a philosophical approach which is consistent with the Mexican American culture.

"Casa Del Sol" utilizes a unique treatment approach that recognizes the intrinsic cultural strengths of the Chicano client and uses these strengths as part of the treatment process. This is accomplished vis-a-vis a cultural assessment of the client at the point of intake. The assessment is then used towards developing client cultural profiles and provides the guidelines and parameters for designing appropriate treatment plans, which incorporate a bilingual-bicultural character.

The cultural assessment and cultural treatment became effective in July, 1976. Since then, all clients served by the program have undergone this unique service delivery system.

An analysis or evaluation of Casa Del Sol's efforts has not been made to assess the particular level of effectiveness and most important the level of impact on the individual's alcoholism behavior. This lead towards carrying out a research project which would yield appropriate data to assist the program in evaluating the levels of impact, changes and degree of decreasing or removing the alcoholism problem.

Since there is not a similar program within the geographic area of San Antonio or elsewhere that employs a cultural approach to treatment, this research effort assumes a high priority character. It will provide the basis and shed light into the importance of advocating for similar programs aimed at Mexican Americans who

struggle to survive in the face of numerous problems of which alcoholism is one.

I. STATEMENT OF THE PROBLEM

Alcoholism As A Social Problem

Increasing national concern and awareness as to the human and social costs of alcohol abuse and alcoholism for the affected individual, his family and community has prompted the establishment of programs aimed at identifying, developing and implementing treatment and research programs. The level of concern has been expressed vis-a-vis the establishment of the National Institute On Alcoholic Abuse and Alcoholism (NIAAA) under the provisions of the Comprehensive Alcohol Abuse and Alcohol Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-66).

The result of this effort has been the culmulation of various studies and information which has shed further light as to the alcoholism dilemma. This, however, has not led towards resolving the issues of developing and operationalizing a universal definition as well as agreement on causation theories.

As a social problem, alcoholism is a complicated phenomenon that easily disguises the causes from effects. In addition, other factors cloud the problem by creating different interpretations of what constitutes an alcoholism problem. Particularly important are the social, physiological, legal and cultural points of reference. Specifically questions that evolve in the process are:

1. What does society tolerate as normal drinking behavior?

2. Does a physiological condition determine when a person becomes an alcoholic?

3. Are DWI's adequate indicators for identifying alcoholic persons?

4. What role does alcoholism play in various cultures?

All of the aforementioned questions examplify the difficulty of arriving of one acceptable definitions. A review of the various definitions used identifies several characteristics of alcoholism. First of all, there does exist agreement that alcoholism is a disease. It is characterized by an abnormal, cnronic dependence on alcohol and many times becomes compulsive.

For purposes of this paper, the operational definition used will be as fol'ows:

> The term "alcoholism" is used to refer to a complex biological, psychological and sociological phenomenon related to the abuse of alcoholic beverages.[1]

Arriving at an operational definition of alcoholism is only half of the problem. The other half relates to the lack of agreement on causation theories. A number of theories have been proposed which have attempted to explain the problem, but have yet proved to be insufficient for universal agreement.

Theories advanced have been the "Psychological Theory", which includes psychoanalytic, learning and personality trait theories. The "Learning Theory" is one which stipulates that alcoholics learn to adapt and cope with situations which are painful and anxiety-ridden by drinking.

Lastly, the "Biogentic Theory" which relates genetically inherited nutritional deficiency, genetic immunity to alcoholism and an endrocrine dysfunction makes up the most prominent of explanations to the problem.

The particular theory of which this research project is mostly related with is the "Multi-Causation Theory".

> The causes of alcoholism are admittedly unknown, although the number of theories that have been advanced are as numerous as the professions and scientific descriptions concerned with the problem. No single theory has yet proved adequate to explain the complex of symptoms which are collectively termed alcoholism, alcohol addiction or alcohol dependence. Most probably, the condition reflects a form of response to an interactive combination of physiological, psychological and sociological factors in an individual and his environment.[2]

The First Special Report To The United States Congress On Alcohol and Health in 1971 supports the "Multi-Causation Theory". Specifically two of the findings explicitly relate to it.

> Whether a person drinks at all, and how much depends primarily on sociocultural variables, as shown in the great differences in the drinking status by such factors as sex, age, social status, region, degree of urbanization and religion.[3]

> Most probably, the condition reflects a form of response to an interactive combination of physiological, psychological and sociological factors in an individual and his environment.[4]

Alcohol Problems: A Report To The Nation By The Cooperative Commission On The Study On Alcoholism further adds to the "Multi-Causation Theory". The specific finding of the report was as follows:

> Many environmental and personaltiy variables have been found to be associated with drinking alcohol-related problems.[5]

As can be reviewed, the "Multi-Causation Theory appears to adequately provide some basis for evaluating the possible causes of alcoholism. It is one theory that comes as close as possible to take a comprehensive view of the problem as well as make appropriate linkages with external factors. Insofar as the general society is concerned, the "Multi-Causation Theory" would be applicable on a wide scale basis. It is when we treat the Chicano alcoholism problem that further inquiry is necessitated. Specifically, the "Multi-Causation Theory" has to be expanded or further dilineated so as to better relate to the Chicano alcoholism problem within the realm of social, cultural, economic and political spheres of influence.

Alcoholism And The Mexican Americans

The Mexican American alcoholic poses a paradoxical situation in attempting to identify, develop and implement an alcoholic service delivery system which adequately meets his needs. Part of the problem stems from isolating the variables interacting to produce alcoholic behavior and developing appropriate models of treatment.

The literature in the field of Chicano alcoholism is sparse. This is reflective of the level of consciousness

American society has had for those not White and middle class.

The existing literature though, does provide some general guidelines as to what forces create alcoholism problems among Chicanos. One factor that is prevalent is the condition of poverty. Studies conducted by the greater Los Angeles Community Action Association of poverty in Los Angeles County indicated that communities with high rates of Spanish surname families also experience higher rates of poverty as demonstrated by low-level incomes.[6] This generally characterizes the national situation as it relates to ethnic and racial minority groups.

Accepting that poverty is most prevalent among minority groups and in this regard Chicanos, how does poverty relate to alcoholism? First of all, poverty as a life situation is usually characterized by chronic distress of varying degrees as well as a sense of helplessness to alter the situation. Symptoms of the situation is usually characterized by unemployment, poor housing, poor health and lack of financial resources which further compounds the problem

Many studies of drinking problems have found that problems are more prevalent among the poor than among the remainder of the population, even though drinking at all is more prevalent among persons of higher social status?

Those of the lowest social position have such higher rates of drinking problems than do others, and they tend to get into

trouble over drinking out of all proportion to the frequency with which they drink heavily. The rates of interpersonal problems from drinking (problems with wife, friends, neighbors, relatives, the police and on the job) tend to be highest among those of lower status in the largest cities.[8]

In the face of such economic conditions, it is not surprising that the natural avenues for relief are limited. One avenue would be the internalizing of such stress which then may lead to high rates of physical and emotional disorder. The second would be the selection of alcoholism as an ameliorative mechanism.

Poverty is definately one link in the causative chain. Another is the social factor and specifically, the nature of relationships that exists between Chicanos and Whites, the social norms of behavior and the extent of interaction.

One must remember that the Chicano occupies a minority status. A status which is built upon "a basically false premise that all Whites are superior to all non-Whites".[9] This belief is supported by a two category system which aims to secure the superior-inferior relationship. As a result, the nature of social relationships lends itself towards creating isolationism and unacceptance of the Chicano.

Insofar as the societal norm of behavior is concerned, it is a White middle class norm. Societal goals are American goals. Chicanos, as Americans, also pursue the same learned goals of success, wealth and abundance which are part of the

American ideology and value system. Yet, Chicanos, because of structural and institutional racism are frequently blocked from obtaining these same societal goals. Racism is a powerful stress factor that can produce in its victims a sense of powerlessness over their lives, hopelessness in the future and fatalism in the present.[10] Fatalism cannot be characteristic of Chicanos since it is applicable to other ethnic minorities.

A third element to be considered as interrelated with causative factors is the phenomenon of cultural conflict. Specifically, it pertains to the problem of acculturation. Briefly, acculturation is that process which an individual undergoes when he is becoming adapted to new cultural patterns. A related concept is that of "Cultural Shock" which describes a socio-emotional state characterized by a lowered capacity to cope effectively within the new culture because of the individual's unfamiliarity with language, traditions, moves, customs, and the like. The greater the difference between the new culture and the old, the greater the intensity and to higher incidences of behavior disorders, among which is alcoholism.[11]

In support of the cultural conflict factor, several studies have been conducted which sheds further light. One study, carried out by Madson (1964), found that Mexican American "agringado" alcoholics experienced value conflict between the Mexican culture and non-acceptance in

the Anglo culture. This, Madsen pointed out led the individual towards drinking and alcoholism problems.

Pearson (1964), commentating on the activities of the Los Angeles Alcoholic Rehabilitation Clinic, reported that non-assimilated Mexican Americans had significantly higher rates of rehabilitation than assimilated Mexican Americans. Graves (1967) found similar results when he compared a population of Indians, Spanish Americans, and Anglo Americans with alcoholic problems. His study found that Spanish-American alcoholics had consistently higher rates of drinking and deviant behavior. Additionally, he found that unacculturated Spanish Americans display strong internalized social and psychological controls from their families and their church which results in lower rates of alcoholism.

If these sociological concepts hold true, then the Mexican American population has a double standard, for he lives in two societies or cultures. He must live and adapt to his style of living first and foremost to the Mexican culture from which he receives constant reinforcement and to the dominant Anglo culture of the United States. This double value system is in itself frustrating.[15]

Another very important factor that needs to be looked at is the availability and prevalence of alcoholic beverages in the barrio. The availability of alcohol within the Barrio (as in any poverty area) is very high and the number of liquor

stores, bars and liquor departments in grocery stores is significantly higher than in a comparable high community.[16]

This is exactly the case in San Antonio as demonstrated by a graduate research study carried out by Canales.[17] The study showed that a high number of licensed liquor establishments were found in areas having high levels of poverty and high concentrations of Mexican Americans. Thus, Chicano alcoholism is interwoven with the attractiveness, availability, legality and economic investment of alcoholism by the Anglo society.

The last factor that needs to be considered in reviewing the Chicano alcoholism problem is the social role that alcholism plays. Socially, alcoholism is perceived in a highly desirable manner by the Anglo society. The consumption of alcoholic beverages is made to appear desirable, accepted and commonplace. This is easily carried out vis-a-vis popular media. The medium provided is made to present a relationship with manliness, sophistication, pleasure and socialibility, without any negative consequences.

This social portrayal of acceptance and tolerance for alcohol consumption many times creates a dichotomy for Chicanos. On the one side, the Chicano is led to believe that drinking is socially accepted. The other is that he pays the price in the form of legal constraints. This is directly related to the rate of drunk related arrests. Cazares and other (1972) in a joint graduate research project reported differential arrest rates

for drunk driving between East Los Angeles and other Los Angeles City Police and Los Angeles County Sheriff's Department. The authors found that in 1968, there were 800 arrests per month or 9,676 arrests per year in the East Los Angeles area as compared to 125 per month of 1,552 per year in a more affluent, White community.

Additionally, in a study entitled American Attitudes Toward Alcohol and Alcoholism by Harris and Associates (1971), seems to present the situation as it really exists. One of their findings was as follows:

> Those of upper socioeconomic levels have a much greater range of options in life including less possibility of being fired or arrested for showing the effects of drinking.[19]

Medical Models Of Treatment And The Chicano Alcoholic

The particular medical models of treatment that have been tried with Chicanos have not had widespread impact. This is due to certain inherent limitations. First of all, it does not recognize the external forces which can influence the physiological responses. Secondly, the medical model attempts to explain the problem simply within the realm of physiological and psychological areas. Anything falling outside these parameters is not accepted. The ensuring result is the misapplication of labels on Chicanos.

A more realistic position is: Alcoholism is clearly present in the Chicano barrio (community). It is suggested that it is a symptom of social pathology and not a manifestation of pathology of the Chicano.[20]

Need For Culturally Based Treatment Modalities

The discussion up to this point has centered on the alcoholism problem definition and the shortcomings and difficulties of providing relevant alcoholism services to Chicanos. It is apparent that little or no attention has been given to the unique cultural, social and environmental factors affecting Chicanos. It is also evident that unless there is such recognition and examination of such forces, the problems related to Chicanos alcoholism will continue to be seen vis-a-vis the perspective of the dominant White middle class culture.

An apparent and viable alternative is the development and implementation of bilingual-bicultural treatment modalities that consider attitudes, values and behavioral patterns of Mexican Americans as they relate to alcoholism. The specific elements of such a modality would be several critical components.

One of these elements would be the identification and incorporation of the Chicano client's strengths and background. This relates to the process of examining the person within the parameters of cultural awareness, consciousness and the level of cultural conflict. To accomplish this, the therapist would of necessity possess a cultural understanding and orientation of the individual. The therapist would have to be cognizant of the client's cultural experience. In addition, have the skills to incorporate in the treatment process, the

family, the barrio as well as relate the socioeconomic and political realities so intensively interwoven with the problem. Such sensitivity and empathy would greatly promote an effective and long lasting results.

Another critical factor of the cultural modality would be the inclusion of bilingual-bicultural trained personnel. This is especially important if the Chicano client is going to be helped. The benefits of this are several. One is the development of trust, understanding and communication. Since the therapist is bicultural and speaks the native language, the client feels move at ease and will respond better.

The second major benefit is the availability of therapists who are agile and can easily adapt to the clients' level of fuctioning and needs. A person, who is bilingual-bicultural, could facilitate the helping process in the shortest amount of time and provide for services which the Chicano client feels comfortable with.

From this overview, it can be assumed that the state of Chicano alcoholism is a poor one. The truth of the matter is that we are just in the infant stages of developing such a treatment modality. The lack of appropriate bilingual-bicultural treatment modalities is a hard reality to accept, and until research provides us with such, Chicano alcoholism will continue to rise and efforts to alleviate it will be null.

II. DESIGN AND METHODOLOGY

Statement Of Purpose

"Casa Del Sol", as a federally funded (NIAAA) demonstration project, has undergone an extensive developmental process. Since it's inception in October of 1974, the program has slowly established the base for developing a relevant Chicano alcoholism service delivery system.

Such a process was not an easy one especially since treatment modalities of this nature are non-existent. There was an enormous amount of time and resources that were expanded in crystalizing its impact model. Many efforts were directed at carefully planning and designing the various intervention activities as well as developing the rationale for program philosophy, orientation and direction.

On July, 1975, the program reached a milestone. It was at this time that the program implemented the "Cultural Assessment Tool" as part of the comprehensive service system. The "Cultural Assessment Tool" assumed a critical role in the treatment process as it becomes the basis for cultural oriented treatment. Refer to Appendix A.

Since that date, "Casa Del Sol" has not been systematically evaluated to assess the fruits of its effort. Thus, the statement of purpose for this research project is:

> To conduct a systematic evaluation (thru a research project) of Casa Del Sol's efforts and effectiveness (impact)* as related to the alcoholic drinking behavior of clients seen thru the inpatient unit during the period of August 1, 1976 to December 30, 1976.

*Impact: Any change in the clients' drinking behavior. The ultimate objective would be complete abstinence or having control of the drinking problem.

It is anticipated that the study will provide the informational base to adequately substantiate the program's thrust and orientation. The data analysis produced would assist in a further development, modification or refinement of the treatment model.

Identification Of Research Questions

The broad research questions addressed in this study are:

- Did Casa Del Sol exert a positive impact on the alcoholic drinking behavior of its clients?
- Is a culturally based treatment modality a viable and realistic concept?

Statement Of Assumptions

There are several assumptions that need to be identified as intrinsic features of Casa Del Sol. These are:

- Alcoholism among Chicanos is principally due to structural deficiencies in the surrounding society. Specifically, this means that such things as institutional racism, job discrimination, etc.., must be addressed by the Chicano and credited with his own drinking problems. That is, the frustrations and limitations brought on by the surrounding structure are the principal causes of Chicano alcoholism.
- One of the basic thrusts of the process is to make the Chicano conscious and aware vis-a-vis cultural reinforcement of the problem situation and at the same time recognize their own strengths and values.
- Utilizing a cultural reinforcement approach will provide the base from which Chicanos will be in a more realistic position to gain the social competency that is needed in order to achieve in the dominant society. This will hopefully instill in the Chicano the motivation and know-how about the surrounding society and its institutions and be able to survive without the use of alcohol.

Statement Of Hypotheses

The hypotheses of which this research effort will attempt to address are:

1. Casa Del Sol will promote an increase of AA attendance meetings.

2. Casa Del Sol will produce an increase in the employment status and days worked.

3. Casa Del Sol will lead towards a decrease of alcohol related arrests and hospitalization.

4. Casa Del Sol will cause a decrease in the frequency and quantity of alcoholic beverage consumption.

Identification and Definition Of Key Variables

The research study will concern itself with the following variables:

- AA Attendence: Since Alcoholic Anonymous has established itself as one alternative for assistance, it is being utilized in this study as an indicator of positive effect. Specifically, the assumption is that attendance of AA meetings will increase the possibility of the alcoholic individual overcoming his problem vis-a-vis the support, reinforcement and assistance received.

- Employment Status: The goal of any rehabilitation effort for alcoholic persons is to make them functional and contributing members of society. Of necessity, this relates to the employment status of the individual. As a general accepted criteria, employment is usually considered as a measure of rehabilitative success.

- Days Employed/Worked: The stability of the rehabilitative effort can be measured thru the individual's length of work period. The goal is to have the alcoholic person working on a regualr basis. For this reason, an index of measurement will be the number of days the person worked after leaving the inpatient unit.

- Alcohol Related Arrests: This variable relates to the number of times the alcoholic person was picked up and jailed for any offense related to his drinking, with the exception of DWI. The reason DWIs are not being considered is because not all of the clients drive a motor vehicle, therefore, it would not be applicable to the whole population.

- Hospitalization: This variable relates to the number of times the client was hospitalized for alcohol-related problems.

- Frequency Of Drinking: Specifically, this variable is the number of days the client drank during a regular week.

- Quantity Of Drinking: This variable concerns itself with the amount of alcoholic beverages that the client consumed on a typical day.

Population

The population used in the study were inpatient clients from Casa Del Sol Residential Program. Clients of the program have to meet any of the following criteria:

- Be between the ages of 17 to 48.

- Preferably reside in MAUC's Special Impact Area, which encompasses thirty-three census tracts in the deep south and west sides of San Antonio, Texas.

- Preferably be Mexican Americans.

During the period of August 1, 1976 to December 30, 1976, approximately thirty four (34) clients were seen thru the inpatient unit. Because of considerations of time and resources available, it was determined that a 50% sample (17 clients) of the population would be used in the study. A single random sample system was utilized in the selection process and 17 male clients were chosen.

Since the selection process was thru random sampling, the study group can be assumed to be representative of the total number of the group. For review of client (study) characteristics refer to Table 1.

Data Collection Process

Data for the study was collected thru the use of a questionnaire (see Appendix C) which was personally administrated as follows:

Intake: As the client came into the program, the inpatient counselor filled out the questionnaire Thru this process, a profile of the client was made as it related to the study variables.

Follow-Up: Thirty days after the client had left the inpatient unit, the outreach worker proceeded to utilize the same questionnaire and fill it out with the client. This provided the necessary data to do the comparisons of post behavior with pre-behavior as it related to the study variables.

III. ANALYSIS AND PRESENTATION OF DATA

Analysis Of Information Relative To The Hypothesis

The information collected and analyzed manually showed that Casa Del Sol had exerted a positive impact on the clients' alcoholic behavior. An analysis of each hypotheses and the data is as follows:

Hypothesis #1: The data collected on AA attendance at the point of intake showed an average attendance rate of less than one meeting (.59). On the data collected at the follow-up, it showed an average attendance rate of 6.29 meetings. This was an increase of 5.7.

Statistical Computation: A T-Test for Related Measures was carried out for this hypothesis and it showed that treatment provided was significant in increasing the attendance rate of AA meetings. The T was 3.9 which was greater than 2.120 at the .05 level.

Hypothesis #2: Data for this hypothesis was collected on two variables: the employment status and the number of days worked. On the employment status, the intake data showed that of the total population (17) only 6% or one client was employed. The follow-up data showed a 47% rate of employment status (8 members employed). This was an increase in the employment status of 41%. No T-Test was carried out for employment status.

On the days worked within the last thirty days, the average number of days worked at the intake point was 3.23 where as the average number of days worked at follow-up was 11.76. This was a positive gain of 8.53 days.

Statistical Computation: A T-Test for Related Measures was conducted on this hypotheses (days worked) and the T was 2.71 which was greater than the 2.120 at the .05 level. This showed that the treatment was significant in increasing the number of days worked.

Hypothesis #3: Data was collected on two variables as it related to this hypothesis: alcohol related arrests and hospitalization. On the alcohol related arrests, the average number of arrests at intake was 1 and the average number of arrests at follow-up was less than one (.24). This was a decrease of .76.

Statistical Computation: A T-Test for Related Measures showed a T of 2.62 which was greater than the 2.120 at the .05 level. Treatment was positive significant factor.

Data collected on the hospitalization rate at intake showed an average of .58 and the rate at follow-up was .06. This was a decrease of .52.

Statistical Computation: A T-Test for Related Measures showed a T of 2.41 which was greater than the 2.120 at the .05 level. This showed a positive effect brought about by the treatment.

Hypothesis #4: Data was collected on two variables: frequency and quantity. Respectfully, the average number of days at intake was 8.47 days whereas at the point of follow-up, there was an average number of 1.67 days. This was a decrease in the number of days by 6.8 days.

Statistical Computation: A T-Test for Related Measures showed at T of 6.3 which was greater than the 2.120 at the .05 level. It showed that the treatment was significant in decreasing the number of days the client drank.

On the variable of quantity, the intake showed an average consumption of 23.9 ounces of alcoholic beverages and of follow-up an average of 5.4 ounces. This was a decrease in the average amount of alcoholic consumption of 18.1 ounces.

Statistical Computation: A T-Test for Related Measures showed a T of 8.09 which was greater than the 2.120 at the .05 level. This indicated that treatment was significant in decreasing the level of alcohol consumption.

Internal and External Validity Factors

Discussions on validity factors affecting the study has to be within the following areas:

History: Since the post-test was made thirty (30) days after the client had terminated his inpatient stay, the attendance of AA meetings might have contributed to the client's behavior. The study did show an increase in AA attendance but this was also a part of the client's treatment program while at Casa Del Sol. Any effect that this might have had was already built into the treatment plan and afterwards any further attendance was seen as supplemental reinforcement to the effort.

Testing: The fact that the study had a pre-test and post-test with the same questions, this might have contributed to the client's awareness as to how to respond with perceived right answers. This, however, would have been very minimal since the duration of time between the pre and post-test was approximately eighty (80) days (average length of stay was 49

days and the 30 days before follow-up) thus being extremely difficult for the client to recollect the individual questions.

Instrumentation: Since staff from the two components were utilized, their orientation might have been different. For example, at intake the counselor is interested at establishing the severity of the individual's drinking problem and will tend to be oriented towards an alcoholic problem definition.

The outreach worker in retrospect would be looking for changes within the person as a whole at follow-up. He would not place particular emphasis on the alcoholism but on a general perspective of the person's functioning, i.e., social, economic, medical, familial, etc..., thus presenting the chance of not obtaining accurate data on the key variables. This was minimized in the design of the questionnaire. The instrument is general and specific enough that all of the areas of behavior functioning are covered, i.e., employment, arrests, residence, medical, etc.. In addition, the staff went through training to become familarized for gathering baseline data.

Multiple Treatment Interference: Many of the clients involved in the project had received alcoholic treatment at other programs (Alcoholic Treatment Program and San Antonio State Hospital) which might have had an effect on the findings. This, however, was very minimal if any because of the cultural component being absent in these programs.

IV. SUMMARY AND CONCLUSIONS

Findings Relative To Research Questions

The research effort seems to identify the following findings:

1. All of the hypotheses were shown to be correct statements. Thru the statistical analysis, the key variables utilized demonstrated positive predicative outcomes.

2. In regards to the research question #1, Casa Del Sol did exert a positive impact on the alcoholic drinking behavior.

3. Research question #2 is supported in an affirmative manner. Since Casa Del Sol is a bilingual-bicultural treatment program, the findings indicate that it is a viable and realistic concept. Imbedded in this is the whole thrust of cultural assessment, culturally individualistic treatment plans and the study of Chicano culture and history to create awareness.

Future Research Questions

This research effort provided some insight into the problem of Chicano alcoholism. Other questions that need to be pursued for a better understanding of Chicano alcoholism are:

1. Will the same treatment effect continue on a prolonged basis? For example, this study covered a thirty day period after inpatient care. What would be the results at 90 days or 180 days?

2. What are identifiable characteristics of the Chicano alcoholic?

3. What are the differences between Chicano alcoholics and Anglo as well as other ethnic minority alcoholic individuals?

4. What is the relationship between social characteristics and alcoholism rates among Chicanos?

5. What are different types/categories of alcoholism that exists in the Mexican American culture?

Policy Implications

The research lends itself to the identification and implementation of the following policy considerations.

1. Research programs specifically directed at Mexican American alcoholism need to intensify and continue on an on-going basis. This would provide the basis for developing appropriate treatment models such as Casa Del Sol.

2. Alcoholism treatment programs serving Chicanos need to take into consideration the particular cultural characteristics as well as socio-economic features; that appropriate mechanisms/ processes be established within the treatment service delivery system, i.e., training of non-Chicanos in the areas of culture, barrio, etc....,

3. An intensive effort should be that treatment programs serving Chicanos have on staff bilingual-bicultural personnel. There could be degree and non-degree persons who have an understanding of the Chicano either because the person has lived the same kind of experiences or is a product of the barrio.

Overall Conclusion

The intent of this research project was to investigate the feasibility of a bilingula-bicultural alcoholism treatment modality The data seems to indicate that it can become a reality and Casa Del Sol represents that reality. It is an example of threading into areas which are still new and undocumented.

As a relevant alcoholism treatment program, Casa Del Sol is only "touching the tip of the iceberg." Much needs to be done. There is a need to document the elements that contribute to alcoholism and alcoholic abuse among Chicanos. Proper identification of attitudes, ideals, and behavior related to drinking among Mexican Americans is needed to develop effective health care systems and prevention programs.

Casa Del Sol is in the infant stages insofar as Chicano alcoholism is concern; but is does represent an effort to develop and implement a relevant, humanistic and culturally based system of services. It is only thru these efforts that we will be able to have the proper data from which to design programs which adequately meet the needs of the Chicanos.

TABLE 1

CLIENT CHARACTERISTICS

	Mean	%
Age	35 yrs.	-
Educational Level	5.4	-
Length Of Stay	48.9 days	-
Residence In Community	26 yrs.	-
Drinking History	15 yrs.	-
Military		
a. Never Served		59(10)
b. Veteran		35(6)
c. In Reserves		6(1)
Past AA Attendance		
a. Never Attended		71(12)
b. Have attended		29(5)

Total Number = 17

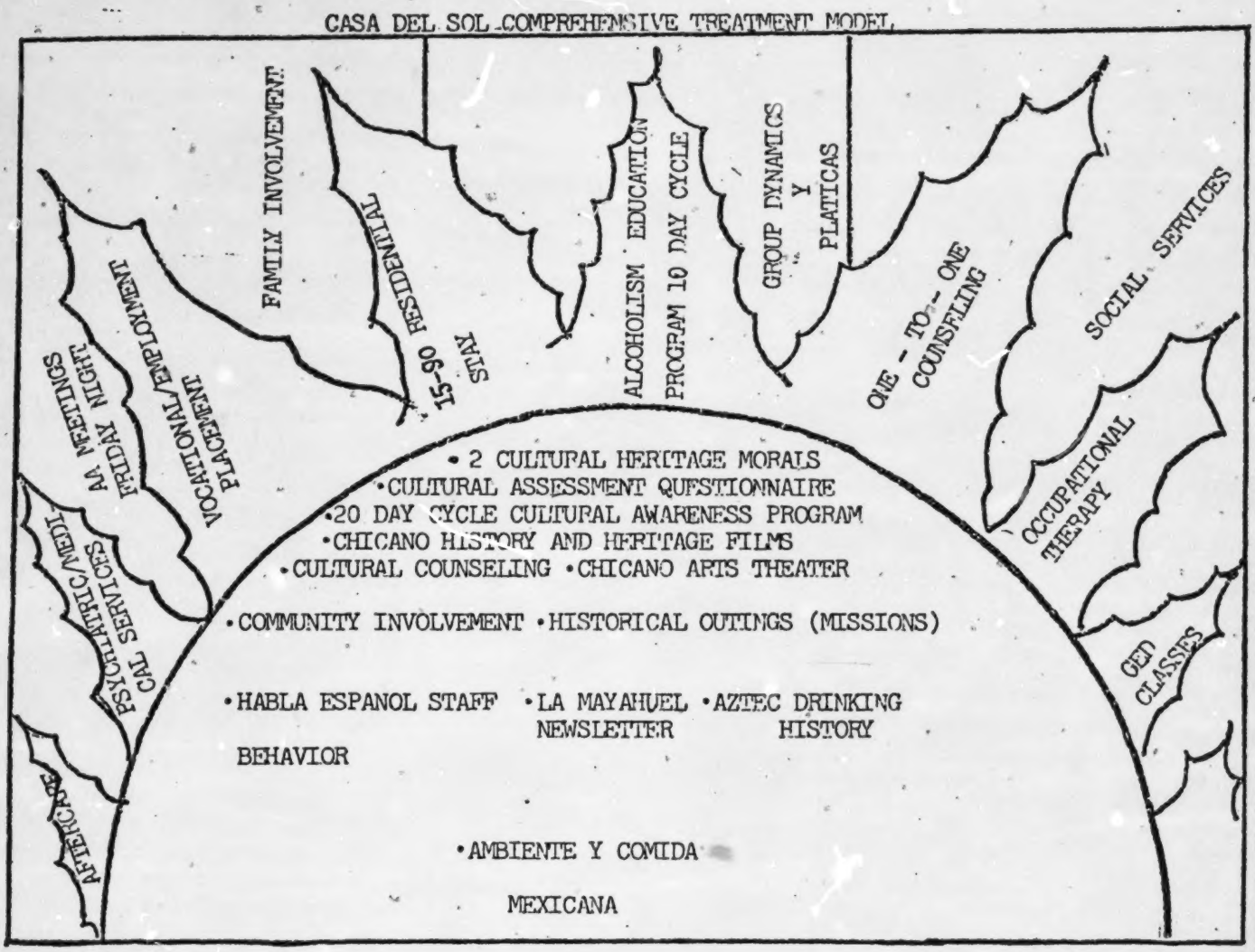
TABLE 2

STATISTICAL DATA ON KEY VARIABLES

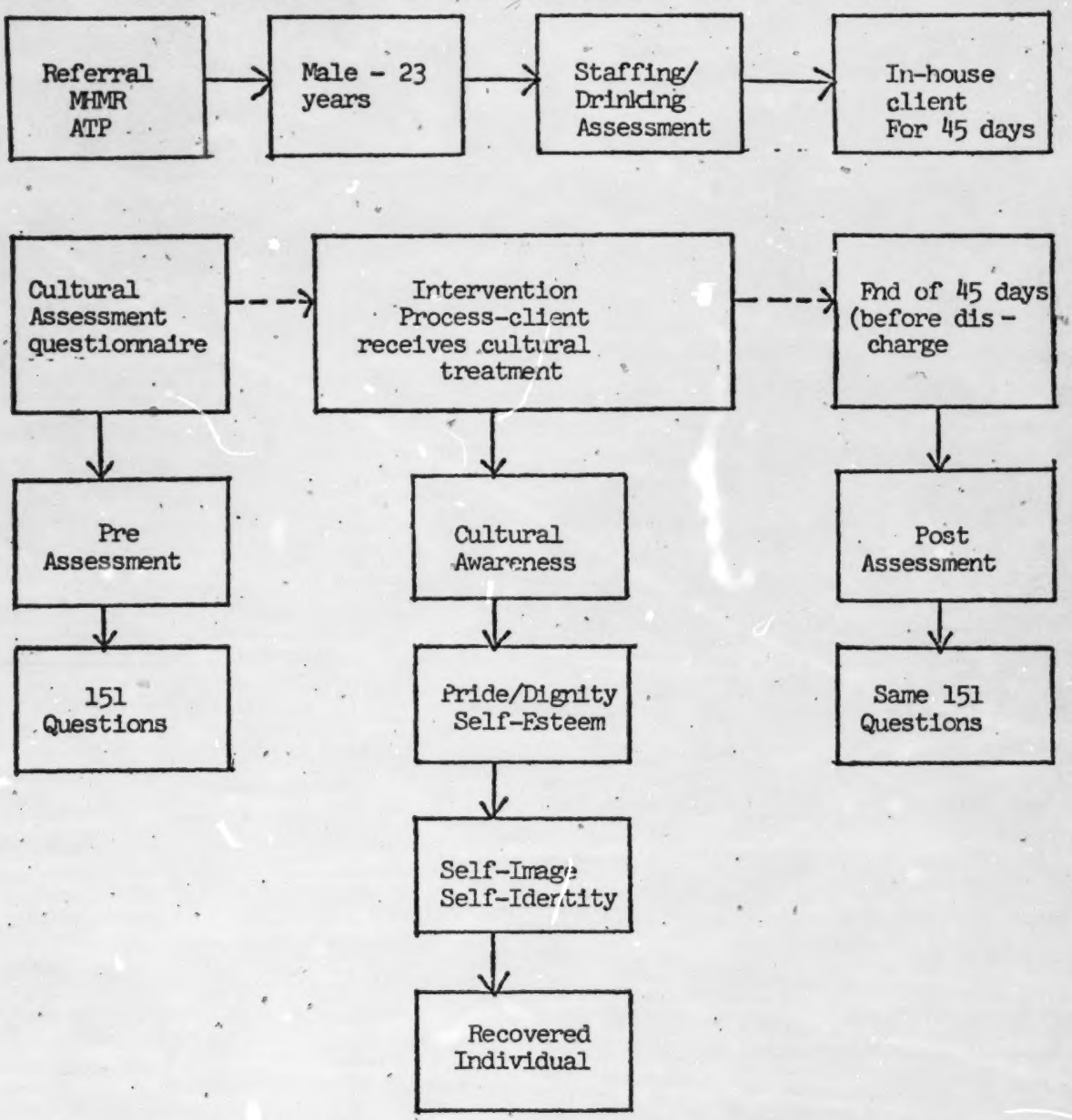
	Pre-Test Mean	Post-Test Mean	T-Test For Rel. Measures	Impact On Variable
1. AA Attendance	.59	5.29	3.9	+
2. Alcohol Related Arrests	1	.24	2.62	+
3. Hospitalization	.59	.06	2.41	+
4. Frequency Of Drinking	8.47	1.67	6.3	+
5. Quantity Of Drinking	23.9	5.4	8.09	+
6. Days Worked	3.23	11.76	2.71	+
7. Employment	.06	.47	*	+

*Was only analyzed in regards to whether the client was employed or not.

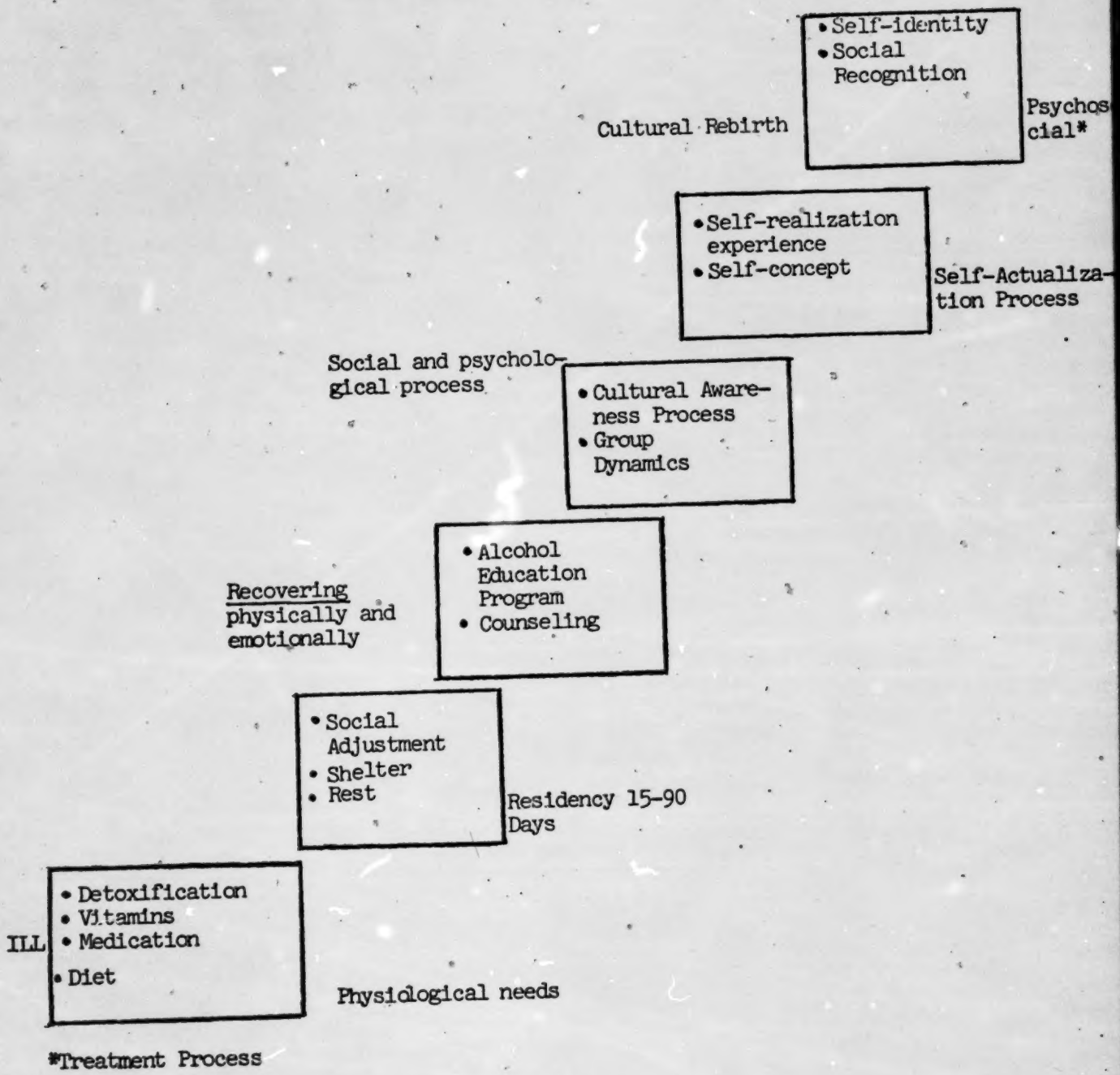
CASA DEL SOL COMPREHENSIVE TREATMENT MODEL



CASA DEL SOL'S CULTURAL FLOW CHART



This is an experimental process with emphasis on the cultural aspects and behavioral characteristics which can contribute to the individual's recovery process.


• Self-identity
• Social Recognition
Cultural Rebirth
Psychos cial*
• Self-realization experience
• Self-concept
Self-Actualiza- tion Process
Social and psycholo- gical process
• Cultural Aware- ness Process
• Group Dynamics
• Alcohol Education Program
• Counseling
Recovering physically and emotionally
• Social Adjustment
• Shelter
• Rest
Residency 15-90 Days
• Detoxification
• Vitamins
• Medication
• Diet
ILL
Physiological needs
*Treatment Process

*This questionnaire is an adaptation of an NIAAA form No. 68-R1313 previously in use.

CASA DEL SOL

ALCOHOLISM PROGRAM

1. Identification Number ___ ___

2. Census Tract ___ ___ ___ ___

3. Age ___ ___

4. Report Type

1. ___Intake
2. ___30 day Follow-Up Report
3. ___60 day Follow-Up Report

5. Report Information (60 day or 180 day report only)

a) Was the interview:
1) ___Not completed (Go On To B)
2) ___Completed or partially completed

b) IF NOT COMPLETED:
Why was the report not completed?
1) ___Client refused interview
2) ___Client moved away
3) ___Client is inaccessible
4) ___Client could not be located
5) ___Client deceased

6A Treatment Status (Check One)
Active Clients
01) ___Emergency care unit
02) ___Detoxification unit
03) ___Inpatient hospital
04) ___Partial hospitalization
05) ___Quarterway house
06) ___Halfway house
07) ___Residential care
08) ___Drop-in unit
09) ___Outpatient

Inactive Clients
10) ___No services during the past 30 days, but not terminated

Terminated Clients
11) ___Inactive 3 months or more
12) ___Treatment completed
13) ___Voluntarily
14) ___Inaccessible
15) ___Client died

6B Length of inpatient stay (days)
1) ___ ___
98) Not Applicable
99) Not ascertain

7) Sex
1) ___ Male
2) ___ Female

8) Residence Information
How long has client lived in his present community or neighborhood?

____ Years

____ Months

9) Present Military Status
What is client's present military status? (Check One)
1) ___Never served
2) ___Veteran
3) ___On active duty
4) ___In reserves

10) Insurance
a) Does client have health insurance?
1) ___No (Go On To 11)
2) ___Yes - does cover alcoholism treatment
3) ___Yes - does not cover alcoholism treatment
4) ___Don't know (Go On To 11)

b) IF YES: What is the principal type of insurance:
1) ___Medicare
2) ___Medicaid
3) ___Blue Cross/Blue Shield
4) ___Private insurance company
5) ___Other_____
(Specify)

11) Education
What was the highest grade client completed in school? (Check One)

01) ___ No schooling
02) ___ 1-4 grade
03) ___ 5-6 grade
04) ___ 7 grade
05) ___ 8 grade
06) ___ 9-11 grade
07) ___ 12 grade
08) ___ Vocational, business, or technical
09) ___ 1 year college
10) ___ 2 years college
11) ___ 3 years college
12) ___ 4 years college
13) ___ Graduate school

12) Annual Income
What was the approximate shared gross income of the household in which client lived during the last calendar year? (Include income from all sources)

01) ___ Less than $1,000
02) ___ $1,000-$1,999
03) ___ $2,000-$2,999
04) ___ $3,000-$3,999
05) ___ $4,000-$4,999
06) ___ $5,000-$5,999
07) ___ $6,000-6,999
98) ___ Not Applicable
99) ___ Not ascertain

13) Drinking History
Approximately how many years has client been drinking frequently or heavily?

14) AA Meetings - Past Attendance
Has client ever attended AA meetings?

1) ___ No
2) ___ Yes

15) Body Weight
What is the client's present body weight?

____ Pounds

16) Marital Status
What is the client's present marital status?

1) ___ Never married
2) ___ Married and living with spouse
3) ___ Widowed
4) ___ Divorced/Annulled
5) ___ Separated

17) Residence Information
a) What type of residence does client live in?

1) ___ House
2) ___ Apartment
3) ___ Mobile home or trailer
4) ___ Rooming house, hotel (Go On To 18)
5) ___ Group quarters (e.g., halfway house, dormitory, mission) (Go On To 18)
6) ___ Homeless (Go On To 18)
7) ___ Other _____ (Specify)

b) If not in group quarters or homeless, what is the total number of persons living in client's household (including client)?

_____ Number

18) Occupation
What is client's current or most recent occupation within the past year?
Note To Interviewer: Describe briefly, e.g., civil engineer, college teacher, elementary school teacher, draftsman, office manager, bookkeeper, bulldozer operator, sheetmetal worker. If client is a housewife or student, so state. If client has not worked during the past year, indicate "none".

_____

_____

_____

_____

_____

19) Employment
a) Does client have a job now?

1) ___ No (Go On To B)
2) ___ Yes, full time (Go On To C)
3) ___ Yes, part time (Go On To C)
4) ___ Yes, odd jobs (Go On To C)

b) IF NO: What is the main reason client is not working? (Check One)

1) ___ Housewife
2) ___ Student
3) ___ Retired/too old
4) ___ Disabled
5) ___ Drinking problem
6) ___ Institutionalized
7) ___ Doesn't want a job
8) ___ No job available
9) ___ Other _____
(Specify)

c) Approximately how many days did client work during the past 30 days?

_____ days

20) Financial Support
What was client's major source of financial support during the last calendar month? (Check One)

1) ___ Job
2) ___ Spouse
3) ___ Family or friends
4) ___ Public assistance (welfare)
5) ___ Pension (include Social Security)
6) ___ Insurance (include Workmen's Compensation, Unemployment Insurance)
7) ___ Savings/Investments
8) ___ None
9) ___ Other_____
(Specify)

21) Monthly Income
What was the client's income from job during the last calendar month?

01) ___ None
02) ___ $85 or less
03) ___ $86-$250
04) ___ $251-$499
05) ___ $500-$835
06) ___ $836-$1,250
07) ___ $1,251-$1,699
08) ___ $1,700-$2,500
09) ___ Over $2,500
10) ___ Unwilling to state

22) AA Meetings - Present Attendance
How many times did client attend AA meetings during the past 30 days? (If None, Record "00")

____ Numbers

23) Other Alcoholism Treatment

a) Is client presently receiving alcoholism treatment services, other than AA, at another agency?

1) ___ No (Go On To 24)
2) ___ Yes

b) IF YES: Specify name of agency.

24) Motor Vehicle Driving and Arrests

a) Does client drive a motor vehicle?

1) ___ No (Go On To 25)
2) ___ Yes

b) IF YES: How many times has client been arrested for driving while intoxicated during the past 30 days?

___ days

25) Other Arrests
How many times has client been arrested for drinking not related to driving during the past 30 days?

____ days

26) Hospitalization
How many times has client been arrested for drinking not related to driving during the past 30 days?

_____Number

27) Institutionalization
How many days has client been institutionalized (e.g., in the hospital, in jail) during the past 30 days?

____days

Note to Interviewer: If at Intake client has been institutionalized during a large portion of the past 30 days, obtain the information requested in questions 28-30 for the 30 days before he was institutionaliz This note does not pertain to Follow- interviews.

28) Drinking Status

a) How long has it been since client's last drink?

1) ____ 1-6 days
2) ____ 1-2 weeks
3) ____ 3-4 weeks
4) ____ 5-8 weeks
5) ____ 9-12 weeks
6) ____ 3-4 months
7) ____ 5-6 months
8) ____ Over 6 months

b) How many days did client drink during the past 30 days?

____ days

29) Drinking Quantity and Frequency

a) About how often did client drink during past 30 days?

Beer	Wine	Liquor
1) ____ Every day	1) ____ Every day	1) ____ Every day
2) ____ 5-6 days a week	2) ____ 5-6 days a week	2) ____ 5-6 days a week
3) ____ 3-4 days a week	3) ____ 3-4 days a week	3) ____ 3-4 days a week
4) ____ 1-2 days a week	4) ____ 1-2 days a week	4) ____ 1-2 days a week
5) ____ Less often than weekly	5) ____ Less often than weekly	5) ____ Less often than weekly
6) ____ None	6) ____ None	6) ____ None

Note to Interviewer: Be sure to complete quantity for each type of drink.

b) About how much did client drink in a typical day in which he drank?

1) ____ 6 quarts or more	1) ____ 5 fifths or more	1) ____ 4 pints or more
2) ____ 5 quarts	2) ____ 3-4 fifths	2) ____ 3 pints
3) ____ 4 quarts	3) ____ 2 fifths	3) ____ 2 pints
4) ____ 3 quarts	4) ____ 1 fifth	4) ____ 1 pint
5) ____ 1-2 quarts	5) ____ 2 water glasses/ 3-5 wine glasses	5) ____ 8-10 shots or drink
6) ____ 1-3 glasses	6) ____ 1 water glass/2 wine glasses	6) ____ 5-7 shots or drinks
7) ____ None	7) ____ None	7) ____ 3-4 shots or drinks
		8) ____ 1-2 shots or drinks
		9) ____ None

Note to Interviewer: 1 quart = three 11 oz. bottles (cans) or four 8 oz. glasses. 1 fifth is a standard size bottle and is equal to about three 8 oz. water or six 4 oz. wine glasses. There are 5 fifths in a gallon or 2 1/2 fifths to a half gallon. 1 pt.=16 oz. or just over ten 1 1/2 oz. shots. There are 2 pts. in 1 qt. and a little over 1 1/ pts. in a fifth.

30) Behavioral Aspects of Drinking

Not to Interviewer: Determine the follcwing for client during past 30 days.

a) Number of times drunk	1)___None	2)___1-4	3)___5-10	4)___More than 10
b) Longest period between drinks	1)___12 hrs. or more	2) --	3)___Less than 12 hrs.	4)___None
c) Longest period of continued drinking	1)___Less than 6 hrs.	2)___6-12 hrs.	3)___More than 12 hrs.	4)___None
d) Number of days had drink upon awaking	1)___None	2)___1-4	3)___5-10	4)___More than 10
e) Meals missed because of drinking	1)___None	2)___1-4	3)___5-10	4)___More than 10
f) Drinking alone or with others	1)___None	2)___Mostly with others	3)___Sometimes alone, Sometimes with others	4)___Mostly alone
g) Number of memory lapses or "blackouts"	1)___None	2)___1-2	3)___3-5	4)___More than 5
h) Number of times had the "shakes"	1)___None	2)___1-2	3)___3-5	4)___More than 5
i) Number of nights had difficulty sleeping	1)___None	2)___1-2	3)___3-5	4)___More than 5
j) Number of quarrels with others while drinking	1)___None	2)___1-2	3)___3-5	4)___More than 5
k) Drinking while on job/ during daily activities	1)___No	--	3)___Yes	4)___ --
l) Days of work missed/ days of inactivity because of drinking	1)___None	2)___1-2	3)___3-5	4)___More than 5

31) Client Self-Perception of Drinking
Note to Interviewer: Question 31 is to determine client's view of his drinking. Do not give your opinion.

How would you describe your drinking behavior at the present time?
1)___No drinking at all
2)___Occasional drinking
3)___Frequent drinking
4)___Problem drinking on sprees
5)___Steady problem drinking

32) Interviewer Perception of Client's Drinking

a) Based on this interview and your knowledge of the client, how would you assess the client's drinking behavior?
1) ___ No problem
2) ___ Slight problem
3) ___ Moderate problem
4) ___ Severe problem

Note to interviewer: Answer question 32(b) only this is a Follow-Up interview. Do not answer it at Intake.

b) 1) ___ Worsened
2) ___ No change
3) ___ Moderately improved
4) ___ Greatly improved

33) Other Drugs

a) Did client use drugs other than alcohol (including prescrption drugs) during the past 30 days?
1) ___ No
2) ___ Yes

IF YES: Specify the three most frequently used drugs and check how often each was used.

b) 1)_____ Drug Type
(Specify)

2) How often used:
1) ___ Less than once a week
2) ___ Once a week
3) ___ More than once a week
4) ___ Daily

c) 1)_____ Drug Type
(Specify)

2) How often used:
1) ___ Less than once a week
2) ___ Once a week
3) ___ More than once a week
4) ___ Daily

d) 1)_____ Drug Type
(Specify)

2) How often used:
1) Less than once a week
2) Once a week
3) More than once a week
4) Daily

Note to Interviewer: This checklist should not be read to client. It is for coding purposes only.

1) Heroin
2) Methadone
3) Other opiates and synthetics (Codeine Demerol, Morphine, Percodan)
4) Barbiturates and other sedatives (Nembutal, Phenobarbital, Seconal)
5) Amphetamines (Benzedrine, Dexedrine, Methamphetamine)
6) Cocaine
7) Marijuana, Hashish, THC
8) Hallucinogens, psychedelics (DMT, LSD Mescaline, Psilocybin, STP, Scopotamine)
9) Psychotropics (Librium, Valium)
10) Ihalents
11) Non-prescription over-the-counter drugs (cough medicine, etc.
12) Other

CODING MANUAL

Column No.	Question	Items
1-2	Ident. No.	
Blank-3		
4-5-6-7	Census Tract	Census Tract
8-9	Question #3	Age
10	Question #4	Report Type 1. Intake - Halfway House 2. 30 day follow-up report 3. 60 day follow-up report
11	Question 5A	Report Information Was the interview: 1. Not completed (go on to 5b) 2. Completed or partially completed
12	Question 5B	If not completed: Why was the report not completed? 1. Client refuse interview 2. Client moved away 3. Client is inacessible 4. Client could not be located 5. Client deceased 98. Not applicable 99. Not ascertain
13-14	Question 6A	Treatment Status Active Clients 1. Emergency care unit 2. Detoxification unit 3. Inpatient Hospital 4. Partial hospitalization 5. Quarterway house 6. Halfway house 7. Residential care 8. Drop-in unit 9. Outpatient

Column No.	Question	Items
		Inactive Clients
		10) No services during the past 30 days, but not terminated
		Terminated Clients
		11) Inactive 3 months or more
		12) Treatment completed
		13) Voluntarily
		14) Inaccessible
		15) Client died
		98) Not applicable
		99) Not ascertain
15-16	Question 6B	Length of inpatient stay (days)
		01) 1 day
		02) 2 days
		03) 3 days
		04) 4 days
		98) Not applicable
		99) Not ascertain
17	Question #7	Sex
		1. Male
		2. Female
18-19-20	Question #8	Residence Information (months)
		012 - 1 years
		024 - 2 years
		048 - 4 years
		060 - 5 years
Blank-21		
22	Question #9	Present Military Status
		1. Never Served
		2. Veteran
		3. On active duty
		4. In reserves
		98. Not applicable
		99. Not ascertain
23	Question #10A	Insurance
		Does client have health insurance?
		1. No (go on to 11)
		2. Yes - does cover alcoholism treatment
		3. Yes - does not cover alcoholism treatment
		4. Don't know (go on to 11)

Column No.	Question	Items
24-25	Question 10B	If yes: what is the principal type of insurance 1. Medicare 2. Medicade 3. Blue Cross/Blue Shield 4. Private Insurance 5. Other 98. Not applicable 99. Not ascertain
26-27	Question #11	Education What was the highest grade client completed in school? 1. No schooling 2. 1-4 grade 3. 5-6 grade 4. 7 grade 5. 8 grade 6. 9-11 grade 7. 12 grade 8. Vocational, business, or technical 9. 1 year college 10. 2 years college 11. 3 years college 12. 4 years college 13. Graduate school
Blank-28		
29-30	Question #12	Annual Income What was the approximate shared gross income of the household in which client lived during the 1 last calendar year? 1. Less than $1,000 6. 5,000-5,9 2. $1,000-$1,999 7. 6,000-6,9 3. $2,000-$2,999 4. $3,000-$3,999 5. $4,000-$4,999 98. Not applicable 99. Not ascertain
31-32	Question #13	Drinking History 1. 1 year 2. 2 years 98. Not applicable 99. Not ascertain

Column No.	Question	Items
33	Question #14	AA Meetings - Past Attendance 1. No 2. Yes
Blank-34		
35-36-37	Question #15	Body Weight (Pounds)
38	Question #16	Marital Status 1. Never Married 2. Married and living with spous 3. Widowed 4. Divorced/Annulled 5. Separated
39	Question #17A	Residence Information What type of residence does clien live in? 1. House 2. Apartment 3. Mobile home or trailer 4. Rooming house, hotel (go on to 18) 5. Group quarters (e.g., halfway house, dormitory, mission) (go on to 18) 6. Homeless (go on to 18) 7. Other
Blank-40		
41-42	Question #17B	Number of individuals in househol 01 - 1 person 02 - 2 persons 98. Not applicable 99. Not ascertain

43-44 Question #18 Occupation

01) Custodian	10) Carpenter	19) Evangelist
02) Landscapper	11) Streetpaver	20) Packer
03) Butcher/Meatcutter	12) Carpet Layer	21) Machinist
04) Barber	13) Pipe Fitter	22) Furniture Mover
05) Student	14) Plumber	23) Shop Porter
06) Warehouseman	15) Auto Mechanic	24) Counselor
07) Landscapper/Migrant	16) Construction Worker	98) Not Applicable
08) Housepainter	17) Store Manager	99) Not Ascertain
09) Cement Finisher	18) Migrant	

Column No.	Question	Items
45	Question #19A	Employment Does client have a job now? 1. No (go on to b) 2. Yes, full time (go on to c) 3. Yes, part time (go on to c) 4. Yes, odd jobs (go on to c)
46-47	Question #19B	If No: What is the main reason client is now working? 1. Housewife 2. Student 3. Retired/too old 4. Disabled 5. Drinking problem 6. Institutionalized 7. Doesn't want a job 8. No job available 9. Other
48-49	Question #19C	Approximately how many days did client work during the past 30 days.
Blank-50		
51-52	Question #20	Financial Support What was client's source of financial support during the last calendar month? 1. Job 2. Spouse 3. Family or friends 4. Public assistance (welfare) 5. Pension (include soc. sec.) 6. Insurance (include Workmen's Compensation, Unemployment Insurance) 7. Savings/Investments 8. None 9. Grants 10. Treatment Facilities 11. Food Stamps
53-54	Question #21	Monthly Income 1. None 2. $85 or less 3. $86-250 4. $251-499 5. $500-835 6. Don't know 7. Unwilling to state 8. Not applicable 9. Not ascertain
Blank-55		

Column No.	Question	Item
56-57	Question #22	AA Meetings - Present Attendance (times) 00 - None 01 - one time 02 - two times 98 - Not applicable 99 - Not ascertain
58	Question #23A	Other Alcoholic Treatment 1. No 2. Yes
59-60	Question #23B	Name Of Agency 01. S.A.S.H. 02. VA - MH/MR/Brooks 03. MH-MR - ATP 04. Victory Temple
Blank 61		
62	Question #24A	Motor Vehicle Driving and Arrests 1. No 2. Yes
63-64	Question #24B	Times Arrested 01 - one time 02 - two times 98 - Not applicable 99 - Not ascertain
65-66	Question #25	Other Arrests (Times) 01 - one time 02 - two times 03 - three days 98 - Not applicable 99 - Not ascertain
67-68	Question #26	Hospitalization (times) 01 - one time 02 - two times 98 - Not applicable 99 - Not ascertain
69-70	Question #27	Institutionalization (days) 01 - one day 02 - two days 03 - three days 98 - Not applicable 99 - Not ascertain
Blank-71		

Column No.	Question	Items
72-73	Question #28A	Drinking Status 1. 1-6 days 2. 1-2 weeks 3. 3-4 weeks 4. 5-8 weeks 5. 9-12 weeks 6. 3-4 months 7. 5-6 months 8. Over 6 months
Blank-74		
75-76	Question #28B	Days 01. One day 02. Two days 03. Three days 97. None 98. Not Applicable 99. Not Ascertain
Blank 77-79		
80	Card No. 1	

2nd Card

Column No.	Question	Item
1-2	Ident. No.	
Blank-3		
	Question #29A	Drinking Quantity and Frequency How often did client drink during the past 30 days?
4		Beer 1. Every day 2. 5-6 days a week 3. 3-4 days a week 4. 1-2 days a week 5. Less often than weekly 6. None
5		Wine 1. Every day 2. 5-6 days a week 3. 3-4 days a week 4. 1-2 days a week 5. Less often than weekly 6. None
6		Liquor 1. Every day 2. 5-6 days a week 3. 1-2 days a week 4. 1-2 days a week 5. Less often than weekly 6. None
7	Question #29B	How much did client drink in a typical day?
		Beer 1. 6 quarts or more 2. 5 quarts 3. 4 quarts 4. 3 quarts 5. 1-2 quarts 6. 1-3 glasses 7. None
8		Wine 1. 5 fifths or more 2. 3-4 fifths 3. 2 fifths 4. 1 fifth 5. 2 water glasses or 3-5 wine glasses 6. 1 water glass or 1 or 2 wine glasses 7. None

Column No.	Question	Item
9		Liquor 1. 4 pints or more 2. 3 pints 3. 2 pints 4. 1 pint 5. 8-10 shots or drinks 6. 5-7 shots or drinks 7. 3-4 shots or drinks 8. 1-2 shots or drinks 9. None
Blank-10		
11	Question #30A	Behavioral Aspects of Drinking - Number of Times Drunk 1. None 2. 1-4 3. 5-10 4. More than 11 98. Not applicable 99. Not ascertain
12	Question #30B	Longest Period Between Drinks 1. 12 hrs. or more 2. -- 3. Less than 12 hrs. 4. None
13	Question #30C	Longest Period of Continued Drinking 1. Less than 6 hours 2. 6-12 hours 3. More than 13 hours 4. None
14	Question #30D	Number of days had drink upon awakening 1. None 2. 1-4 3. 5-10 4. More than 11
15	Question #30E	Meals missed because of drinking 1. None 2. 1-4 3. 5-10 4. More than 11
16	Question #30F	Drinking alone or with others 1. None 2. Mostly with others 3. 3-5 4. More than 6

Column No.	Question	Item
17	Question #30G	Number of memory lapses or blackouts 1. None 2. 1-2 3. 3-5 4. More than 6
18	Question #30H	Number of times had the shakes 1. None 2. 1-2 3. 3-5 4. More than 6
19	Question #30I	Number of nights had difficulty sleeping 1. None 2. 1-2 3. 3-5 4. More than 6
Blank-20		
21	Question #30J	Number of quarrels with others while drinking 1. None 2. 1-2 3. 3-5 4. More than 6
22	Question #30K	Drinking while on job/during daily activities 1. No 3. Yes
23	Questions #30L	Days of work missed/days of inactivity because of drinking 1. None 2. 1-2 3. 3-5 4. More than 6
Blank-24		
25	Question #31	Client self perception of drinking 1. No drinking at all 2. Occasional drinking 3. Frequent drinking 4. Problem drinking or sprees 5. Steady problem drinking 98. Not applicable 99. Not ascertain

Column No.	Question	
26	Question #32A	Interviewer perception of clients drinking 1. No problem 2. Slight problem 3. Moderate problem 4. Severe problem 5. Don't know 98. Not applicable 99. Not ascertain
27	Question #32B	Drinking behavior since last interview 1. Worsened 2. No change 3. Moderately improved 4. Greatly improved 98. Non-Applicable
Blank 28-29-30		
31	Question #33A	Other Drugs - Clients use of drugs other than alcohol during past 30 days. 1. No 2. Yes
32-33	Question #33B1	Specify three most frequently Drug Type Checklist 1. Heroin 2. Methadone 3. Other opiates and synthetics (Codeine, Demeral, Morphine, Percodan) 4. Barbiturates and other sedati (Nembutal, Phenobarbital, Seconal) 5. Amphetamines (Benzedrine, Dexedrine, Methamphetamine) 6. Cocaine 7. Marijuana, Hashish, THC 8. Hallucinogens, psychedelics (DMT, LSD, Mescaline, Psilocybin, STP, Scopotamine) 9. Psychotropics (Librium, Valiu 10. Non-prescription over-the-counter drugs (cough medicine etc.) 11. Other

34-35	Question #33B2	How often used: 1. Less than once a week 2. Once a week 3. More than once a week 4. Daily
Blank 36		
37-38	Question #33C2	Specify drugs 1. 2.
39-40	Question #33C2	How often used 1. Less than once a week 2. Once a week 3. More than once a week 4. Daily
Blank 41		
42-43	Question #33D1	Specify 1. 2. 3.
44-45	Question #33D2	How often used: 1. Less once a week 2. Once a week 3. More than once a week 4. Daily
46-79 Blank		
80	Card 2	

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